TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DWAIN KLOSTERMANN, OT, CEAS II

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-3405-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I called TMIF for clarification and was informed that cardio needed to be on treadmill or step test. Patient had performed cardio on treadmill but it was not documented under Cardiovascular Health Profile. Therapist moved the documentation to that area and an appeal was faxed in on 2/16/15."

Amount in Dispute: $1,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed an FCE but used a step test for the cardiovascular testing, which is inconsistent with the requirement to use a treadmill or stationary bike at 134.204(g)(3)(C)."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2014	CPT Code 97750-FC (16 units) Functional Capacity Evaluation (FCE)	$1,200.00	$699.16

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.

- CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 876-Required documentation missing or illegible, see rule 133.1; 133.210l; 129.5; or 180.22.
- 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- A07-Documentation does not meet the level of service required for FCE per Rule 134.204(G)3(C).
- CAC-150-Payer deems the information submitted does not support this level of service.
- CAC-W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Oriignal payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

1. Does the documentation support the level of service billed?
2. Is the requestor entitled to reimbursement for the FCE performed on December 16, 2014?

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

   On the disputed date of service, the requestor billed CPT code 97750-FC.

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

   The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

   28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:
   (1) A physical examination and neurological evaluation, which include the following:
   (A) appearance (observational and palpation);
   (B) flexibility of the extremity joint or spinal region (usually observational);
   (C) posture and deformities;
   (D) vascular integrity;
   (E) neurological tests to detect sensory deficit;
   (F) myotomal strength to detect gross motor deficit; and
   (G) reflexes to detect neurological reflex symmetry.
   (2) A physical capacity evaluation of the injured area, which includes the following:
   (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
   (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
   (3) Functional abilities tests, which include the following:

(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
(B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
(D) static positional tolerance (observational determination of tolerance for sitting or standing)."

The respondent denied reimbursement for the FCE because the requestor did not use a stationary bike or treadmill for the cardiovascular endurance test per 28 Texas Administrative Code §134.204(g)(3)(C).

The requestor states in the position summary that "Patient had performed cardio on treadmill but it was not documented under Cardiovascular Health Profile. Therapist moved the documentation to that area and an appeal was faxed in on 2/16/15."

A review of the submitted documentation finds that the requestor did document on page 9 of the FCE that claimant walked on treadmill; therefore, the respondent's denial is not supported. As a result, reimbursement is recommended per fee guideline.

2. Per 28 Texas Administrative Code §134.204(g) to determine the reimbursement for FCEs the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

   Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.

   The 2014 DWC conversion factor for this service is 55.75.

   The Medicare Conversion Factor is 35.8228.

   Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 79605 which is located in Abilene, Texas; therefore, the Medicare locality is "Rest of Texas."

   The Medicare participating amount for CPT code 97750 is $32.09.
   Using the above formula, the MAR is $49.94 per unit. The requestor billed for 16 units; therefore, $49.94 X 16 = $699.16. The respondent paid $0.00. The difference between MAR and amount paid is $699.16. As a result, additional reimbursement is recommended**.**

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $699.16

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $699.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/16/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.